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Mental Illness Stigma's Impact on Perceptions of Intimate Partner Violence Victims: A Mock Juror Study

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Abstract

Intimate partner violence (IPV) is a widespread issue that disproportionately affects women with mental illness. Yet, there is a lack of research on the effects of mental illness stigma on legal perceptions of women with mental illness in IPV cases. The present study experimentally investigated mock jurors' perceptions of IPV cases where the victim has a mental illness and examined the role stigmatization of mental illness played in these perceptions. MTurk participants (N = 191) first completed attitude questionnaires that measured their attitudes towards mental illness and their beliefs about domestic violence. In the second part of the study, participants were randomly assigned to read one of four IPV (criminal assault) mock trial summaries in which the victim's condition was manipulated (i.e., eating disorder, major depressive disorder, fibromyalgia, or no stated illness). Participants individually provided their verdict and rated their perceptions of the victim and defendant (e.g., credibility and blame). Overall, negative perceptions of mental illness predicted negative perceptions of victims across all conditions (e.g., depression stigma predicted victim blame). Whereas perceptions of mental illness as normal predicted more favorable perceptions of the victim (e.g., increase in pity for the victim). Perceptions of depression as normal predicted a decrease in guilty verdicts across the conditions. Furthermore, there was a significant interaction between depression stigma and victim health on both victim blame and anger such that participants at higher levels of depression stigma had lower blame and anger toward the victim with depression compared to no mental illness. Female participants had more sympathy for the victim than male participants. Findings are discussed with regard to improving experiences of IPV victims within the criminal justice system.

Mental Illness Stigma's Impact on Perceptions of Intimate Partner Violence Victims: A Mock Juror Study

Intimate partner violence (IPV) is a broad label that refers to physical, psychological, or sexual abuse carried out by a current or former intimate partner through means of coercive or controlling behavior (Bundock et al., 2013). IPV is a widespread issue across the globe, and in the United States, it impacts an estimated 25% to 35.6% of women and between 7.6% to 28.5% of men (Hahn, McCormick, Silverman, Robinson, & Koenen, 2014). Though IPV is a pervasive public health and criminal justice issue, populations such as ethnic minorities (Stockman, Hayashi, & Campbell, 2015), women with disabilities (Hahn et al., 2014), and women with mental illness (Van Deinse, Wilson, Macy, & Cuddeback, 2018) are disproportionately targeted as victims. Despite the increased prevalence of IPV among women with a mental illness compared to those without (Trevillion, Oram, Feder, & Howard, 2012), the implications of how such conditions impact legal perceptions of victims is not readily explored in the literature. To address this gap, the present study focuses on how mental illness stigma impacts mock juror decision making when a victim of IPV has a mental illness.

It is challenging to know the true rates of IPV perpetrated against people with mental illness due to underreporting of both IPV and mental illness. Though there is a host of reasons as to why both IPV and mental illness go underreported, a leading reason across both categories is fear of stigma; victims may fear being stigmatized as victims (Jordan, 2004), and people with mental illness may fear being stigmatized based on their mental illness (Corrigan, 2004). Existing prevalence estimates vary widely and suggest IPV affects between 22% and 76% of women with severe mental illness depending on how severe mental illness is defined (e.g., mood and psychotic disorders such as major depressive disorder and schizophrenia), the time frame

considered (e.g., past year prevalence versus lifetime prevalence), and the type of abuse experienced by the victim (e.g., physical assault or sexual assault; Van Deinse, et al., 2018).

Compared to the general population, women with disabilities, which can include mental illness, are victimized at higher rates because people with disabilities may be of lower socioeconomic status, face higher rates of isolation, and may need to depend on people more, which would make them targets for abuse (Hahn et al., 2014). Furthermore, women with mental illness who experience IPV may have increased difficulty reporting abuse to the police, and may be more likely to stay in an unhealthy relationship. This is due in part to dealing with social isolation caused by stigma that may result in a woman being eager to please an individual who gives her attention regardless of how poorly she is treated in that relationship (Friedman & Loue, 2007). Not only do women with mental illness experience higher rates of IPV based on reporting trends, but IPV tends to exacerbate their mental health symptoms (Bundock et al, 2013). Thus, after experiencing the initial trauma of abuse, women with mental illness may have increased difficulty seeking services or leaving their current situation as they may be dealing with increased symptoms of mental illness that make contending with such tasks all the more stressful and challenging.

IPV is both a public health problem and legal issue. As such, victims tend to obtain support in a variety of ways, and many seek formal sources of assistance (e.g., civil or criminal court systems; Bell, Perez, Goodman, & Dutton, 2011). Though court intervention alone might not be the best or only way to address IPV, it can end abuse in some cases. It can also connect victims with resources to utilize in their recovery, such as referring them to a domestic violence shelter, helping them fill out a restraining order, and assisting with child support (Bell et al., 2011). Yet, despite the fact that legal intervention is an important means of dealing with IPV,

cases tend to go under-prosecuted and woefully under-convicted; estimates suggest only 57.6% of IPV instances involving arrest result in prosecution, and only 31% of such cases result in conviction (Morrow, Katz, & Choate, 2016). Furthermore, many victims report feeling confused and anxious throughout the process, and that court personnel are often dismissive and insensitive. Negative experiences and overall dissatisfaction with the legal process make victims less likely to report future abuse to law enforcement, which is highly problematic given single court encounters rarely lead to the end of violence (Bell et al., 2011). Literature specifically looking at how victims with mental illness perceive court helpfulness is lacking, but because the legal process is categorically uncomfortable for victims, people dealing with exacerbated mental health issues likely have similar if not more distressing experiences with the criminal justice system.

People who belong to a stigmatized social group such as a person with mental illness are often targets of prejudice and are viewed unfavorably in comparison to the general population (Miller & Major, 2000). Stigma lowers quality of life and overall wellbeing because it inhibits people from seeking out services and positions in society such as health care, jobs, relationships, and housing (Faigin & Stein, 2008). Stigma also has implications for how a person is perceived and treated by others (Miller & Major, 2000). For victims of IPV who have a mental illness, stigma can affect them in two main ways: public stigma and self-stigma (Mackenzie, Visperas, Ogrodniczuk, Oliffe, & Nurmi, 2019). Public stigma is the externalized form of stigma and includes widespread public stereotypes, prejudice, and discrimination against people who are labeled as having a mental illness (Corrigan, 2004). Public stigma also limits available social opportunities for members of a stigmatized group because members of the general public tend to distance themselves socially from people from stigmatized groups. For people with mental

illness specifically, social distancing occurs due to the common misbelief that people with mental illness are dangerous and unsafe to be around (Corrigan, 2004). As a result of public stigma, the general population lacks understanding and awareness about mental illness, so in cases where a victim of IPV has a mental illness, people might be less sympathetic and understanding of a victim's circumstance, and might intentionally or unintentionally discriminate against victims by not believing or supporting them. Likewise, self-stigma is the internalized form of stigma; it is made up of the three same components (i.e., stereotypes, prejudice, and discrimination), but these attitudes, beliefs, and behaviors are one a person holds in reference to them self, and can be incredibly damaging to a person's self-esteem (Corrigan, 2004). Both public stigma and self-stigma could impact stigmatized victims' encounters with the criminal justice system. Self-stigma could result in a victim hesitating to seek out criminal justice support in the first place, and public stigma might affect how jurors perceive stigmatized people and make decisions about their credibility in the event the victim does seek out legal action against the perpetrator.

In addition to dealing with stigmatization, people with a mental illness also contend with stereotypes. Though specific stereotypes vary depending on the mental illness, stereotypes can be distressing for a labeled individual as they present an overgeneralized idea of what a person of a specific group is like and might either pressure a person to live up to an unrealistic standard or label an individual as possessing socially undesirable traits (McGee, 2018). The Stereotype Content Model (SCM) provides a theoretical framework to predict variance in stereotypes, prejudice, and discrimination towards various social groups (Fiske, Cuddy, Glick, & Xu, 2002). The SCM is divided into quadrants by low warmth, low competence, high warmth, and high competence, and various groups are plotted on the Cartesian plane based on how they rank on

warmth and competence in accordance with stereotypes that exist about the group (Fiske et al., 2002). Stereotypes related to mental illness vary depending on the different illness. For instance, mental illnesses such as eating disorders and major depressive disorder generally fall around the same area of the SCM (i.e., moderate on both warmth and competence; Sadler, Meagor, & Kaye, 2012). Although stereotypes surrounding major depressive disorder are a bit mixed ranging from moderate on both warmth and competence (Sadler et al., 2012) to competent but not warm or trustworthy (Fiske, 2012). Other mental illnesses such as schizophrenia fall low on both warmth and competence (Sadler et al., 2012). Though stereotypes about people with mental illness may vary by the mental illness, the consequential effect overall is people are more likely to socially distance themselves from people with mental illness and may be less likely to believe or trust a person with mental illness (Follmer, & Jones, 2017), which could have ramifications for jury decision making.

Given the prevalence of stigma and negative stereotypes of people with mental illness, we sought to examine the implications of such beliefs in the context of an IPV case because evidence in such cases is often ambiguous, and commonly boils down to "he said, she said." Prior research suggests that when evidence in a case is more ambiguous, jurors tend to rely more heavily on their biases (Kleider, Knuycky, & Cavrak 2012). Consequently, jurors in such cases might make their decision based on false beliefs about people with mental illness. The present study focused on eating disorder and major depressive disorder as women are diagnosed with these mental illnesses at higher rates than men. Additionally, eating disorders and major depressive disorder fall in the same quadrant on the SCM (Sadler et al., 2012), so stereotypes regarding these two mental illnesses are largely similar, and control for certain features such as psychotic characteristics or dangerousness that would activate different stereotypes than mental

illness as a general category would.[1] Furthermore, research on eating disorders and major depressive disorder specifically has demonstrated links to IPV victimization. Being diagnosed with an eating disorder correlates with higher rates and increased odds of being a target of IPV (Bundock, Howard, Trevillion, Malcolm, Feder & Oram 2013). Exposure to IPV is associated with a two to three-fold increased risk of major depressive disorder as well as one and a half to two-fold risk of elevated depression symptoms and postpartum depression among women exposed to IPV compared to women not exposed to IPV (Beydoun, Beydoun, Kaufman, Lo, & Zonderman, 2012).

Self-stigma surrounding mental illness focuses primarily on the negative views towards seeking help (Vogel et al, 2019); this form of self-stigma is particularly prominent among people with major depressive disorder and many other mental illnesses (Mackenzie et al., 2019). Research on stigma of major depression has also focused on gender differences in perceptions of major depression, and findings suggest men report more public stigma towards depression and suicide than women (Mackenzie et al., 2019). These results hold implications for the effects of stigma in a legal context in that men might be more likely than women to hold negative beliefs about victims in cases of IPV where the victim has a mental illness; therefore, they may be less likely to render guilty verdicts in these cases.

Literature on stigma specific to eating disorders typically finds that people harbor negative attitudes towards people with eating disorders as they are often thought to be attention-

[1]It is worth noting, Sadler et al. (2012) made no mention of gender as it relates to perceptions of mental illness categories along the SCM, but their findings appear to group together mental illnesses that are more common amongst males (e.g., schizophrenia, substance use disorder) and diagnoses more common amongst females (e.g., major depressive disorder, eating disorders). Thus, the present study avoided confounding mental illness stereotypes with gender stereotypes by limiting the focus to eating disorder and major depressive disorder.

seeking, weak willed, and responsible for their own illness (Griffiths, Mond, Murray, & Touyz, 2015). Griffiths et al. (2015) surveyed people with an eating disorder and found that the two beliefs people with an eating disorder find most hurtful and damaging are the beliefs that they should be able to pull themselves together, and that they are personally responsible for their condition. This verbiage seen in beliefs about eating disorders is incredibly similar to verbiage used by people who support myths about domestic violence (e.g., "she could have just left," "she provoked him;" Policastro, & Payne, 2013). Based on these similarities, in a case where evidence is ambiguous, people who are already likely to blame the victim may be even more likely to blame the victim if they present with an illness that is already victim blame heavy.

The Present Study & Hypotheses

The present study used an experimental mock juror methodology to explore the effects of a victim having a mental illness on perceptions of an IPV case. Participants first completed attitude questionnaires, then they completed a mock juror experiment in which the victim either had an eating disorder, major depressive disorder, fibromyalgia, or no stated illness. Both mental illnesses were compared to fibromyalgia to determine whether stereotyping of mental illness would impact juror decision making differently than a physical illness would. Fibromyalgia is a relevant physical illness to serve as a comparison group in the present study as it bears similarities to mental illness (e.g., exact cause is often unknown, and there are no physical signs of this illness; Friedberg, Sohl, & Halperin, 2008)[2]. Furthermore, we examined the extent to which such biases and prejudice played a role in juror decision making and perceptions of the

[2]Friedberg et al.'s 2008 study focused on medical students' perceptions of fibromyalgia and found medical students readily perceived fibromyalgia similarly to mental illness, but based on results from pilot testing, it appears the general population is able to identify fibromyalgia as a physical condition.

victim. This study presented participants with an IPV case involving a female victim and male defendant in a heterosexual relationship, as women tend to be victimized at higher rates than men, and IPV in heterosexual relationships is perceived as typical (Wasarhaley et al., 2017).

Hypothesis 1: Main effects of victim mental illness on verdict and trial ratings. We hypothesized that participants would render fewer guilty verdicts and have more negative victim perceptions in cases in which the victim had a mental illness compared to the neutral condition and the fibromyalgia condition. Specifically, we expected that participants presented with the major depressive disorder condition would render the least number of guilty verdicts because stigma towards depression is high (Mackenzie et al., 2019). We also expected that participants presented with the eating disorder condition would also be less likely to render guilty verdicts compared to no mental illness considering eating disorder stigma reflects some of the same sentiments seen in victim blaming (Griffiths et al., 2015; Policastro, et al., 2013). However, based on mixed literature as to where eating disorders fall on the SCM ranging from moderately on both warmth and competence (Sadler et al., 2012) to a more favorable placement (i.e., both competent and warm; Fiske, 2012), these participants may be more likely to render guilty verdicts than the major depressive disorder condition. Though not a primary comparison of interest, participants' reactions and verdicts in the fibromyalgia condition could either fall similar to the neutral condition or may evoke more sympathy towards the victim as victims with a physical condition may be conceptualized as more vulnerable than other victims.

Hypothesis 2: Moderating effects of stigma on verdict and trial ratings. Our main focus of interest in this study was examining how stigma plays a role in juror decision making. As such, we expected that stigmatization would have a moderating effect on verdict and trial ratings, as participants that had negative attitudes towards mental illness and were presented with

one of the mental illness conditions would be significantly less likely to render guilty verdicts than all other participants and would have more negative victim attitudes (e.g., victim blame). This hypothesis is consistent with literature that finds people tend to rely on their biases and prejudice when evidence in a case is ambiguous (Kleider, et al., 2012).

Hypothesis 3: Participant gender effect. Furthermore, past mock juror studies have found a participant gender effect with female participants rendering more guilty verdicts and reporting more sympathy towards the victim than male participants (Dunlap, Lynch, Jewell, Wasarhaley, & Golding, 2015). We therefore expected participant gender to have a main effect on verdicts such that male participants would be less likely to render guilty verdicts than female participants overall. We also expected that participant gender would interact with victim illness condition such that male participants exposed to one of the mental illness conditions will render the least number of guilty verdicts as men have been found to hold more stigmatizing attitudes towards mental illness than women (Makenzie et al., 2019).

Hypothesis 4: Correlation of scores on attitude scales. We also hypothesized participant scores on the various mental illness attitude scales (depression stigma scale, personal responsibility for mental illness subscales, and social distancing) would positively correlate with each other, and negatively correlate with scores on continuity with normal subscales (the perception that eating disorders or major depressive disorder are normal). Though there is no prior research as to whether stigma towards mental illness and acceptance of domestic violence myths would correlate, we predicted that people who support myths about mental illness would also support myths about domestic violence as participants who are judgmental in their beliefs likely also believe a person gets what they deserve (e.g., belief in a just world).

Method

Participants

Participants were recruited through Amazon's Mechanical Turk (MTurk) service. MTurk is an online labor market where researchers and companies can post tasks for people to complete for compensation. This platform has become increasingly popular among social science researchers to conduct surveys and experiments (Mason, & Suri, 2012). Participants were required to be U.S. citizens and at least 18 years of age (i.e., jury eligible). We initially recruited 441 participants to answer questions about their demographics, attitudes, and beliefs that are typical of questions that might be asked during jury selection. Participants in the first part of the study were compensated $0.60 for completing the questionnaires. After screening the original sample for possible fraudulent responses (e.g., "bots;" Dreyfuss, 2018), we then invited everyone that successfully completed the first survey to complete the mock juror study five days later. This portion of the study was filled on a first-come-first-serve basis, and we collected a sample of 264 participants that consented to participate. These participants were compensated $1.15 for completing the study. Prior to analyses, six were removed from the dataset because they were exposed to more than one condition, twelve were removed for not completing the trial questions, four were removed because they did not answer the manipulation check asking if the victim had a mental illness, and fifty-one were removed for selecting the wrong diagnosis in the manipulation check questions.

We were left with a final sample size of 191 participants ranging from ages 21 to 73 (M = 41.9, SD = 12.64). The sample was primarily White/Caucasian (81.2%), with 7.9% Asian or Pacific Islander, 7.3% Black/African American, 6.3% Hispanic/Latino, 2.6% Native American, and .5% Middle Eastern, and .5% Other. Just over half of the sample identified as female (51.8%), and 48.2% of the sample identified as male. The vast majority of participants were

heterosexual (93.2%), with 2.6% homosexual, 2.6% bisexual, and 1% other/prefer not to say. All participants except for one had at least a high school degree or equivalent, and 62.8% had a Bachelor's degree or higher. Within our sample, 27.2% of participants reported being single, never married, 4.7% in a relationship, not living together, 14.1% in a relationship, living together, 45.5% married, 2.1% widowed, and 6.3% were divorced. Of our sample, 58.1% participants reported knowing someone with a mental illness, and 20.4% participants reported experiencing a mental illness themselves. On average, the sample was slightly liberal (M = 3.51; SD = 1.88; scores ranged from 1 = *very liberal* to 7 = *very conservative*) and slightly non-religious (M = 3.50; SD = 2.29; scores ranged from 1 = *not at all religious* to 7 = *extremely religious*).

Materials

Demographic questionnaire. Participants were asked to provide demographic information such as age, gender, sexual orientation, ethnicity, level of education, religiosity, political affiliation, experience with mental illness, and marital status.

Criminal trial summary. Participants read a fictional criminal trial summary of an IPV case in which the male victim allegedly physically abused his female partner with whom he was cohabitating (see Appendix). This study used a between-participants four-cell experimental design. The trial summaries varied as to whether the victim had an eating disorder, major depressive disorder, fibromyalgia, or no stated illness. For the present study, we adapted a domestic violence trial summary used by Wasarhaley et al. (2017). Each condition contained the same general information and was roughly the same length. They only varied in details specific to the manipulation (i.e., whether the victim has an eating disorder, major depressive disorder, fibromyalgia, or no stated illness). Pilot testing conducted among a separate MTurk sample (n =

52) that was demographically similar to our final sample (e.g., 57% female, 77% White, mean age of 38) rated each of these diagnoses as equally serious (eating disorder $M = 6.00$, $SD = 1.00$, major depressive disorder $M = 5.79$, $SD = 1.06$, and fibromyalgia $M = 5.42$, $SD = 0.90$; scores ranged from 1 = *not at all serious* to 7 = *extremely serious*). Each summary included a description of the trial, the prosecution's case, the defense's case, and the judge's instructions. The description of the trial indicated when the altercation between the defendant and alleged victim occurred, and indicated that the defendant was being tried for fourth degree assault to which he pleaded not guilty.

The prosecution's case included testimony from the victim and a second witness. The victim stated she was cleaning the kitchen when her husband came home from work, started nagging her about household chores, and called her an insult specific to the experimental manipulation (e.g., anorexic deadbeat, cry baby deadbeat, crippled deadbeat, or deadbeat). Their arguing and anger intensified from there and the alleged victim stated she told the defendant she was going to leave him if he did not back off, at which point the defendant allegedly grabbed her by the arm and punched her in the face, knocking her to the floor, and he kicked her on her hip. The second witness for the prosecution was a doctor who performed the physical exam on the alleged victim in the emergency room after the incident. He stated the alleged victim's injuries were consistent with the description of the incident, but he did not know how the injuries were sustained or who, if anyone, had caused them.

The defense's case included testimony from a character witness and the defendant himself. The first witness was a co-worker of the defendant. She indicated she had worked with the defendant for five years and felt the defendant was a caring person and excellent employee. She had also stated that on the night before the incident, the defendant had mentioned having

relationship issues that he planned to talk to his girlfriend about. Though he seemed upset with his girlfriend, the co-worker said he did not seem angry. She also stated in the five years she had known the defendant he has never had any issues at work, but she did admit she does not see everything he does, and he does not tell her everything. The defendant testified that when he arrived home he found the alleged victim lazily cleaning the kitchen, and she still had not done the laundry as she promised to do. He tried to talk to her about putting more effort in to household duties, but she called him a "nagging bastard." The defendant stated he tried to comfort her by putting an arm around her, but the alleged victim pushed him away, and when she threatened to leave he grabbed her accidentally causing her to fall to the floor. He states the alleged victim screamed for him to get away from her, so he left the house. When he returned home he was surprised to see the cops there. He admitted that he and his girlfriend had verbal arguments in the past, but they never hurt each other physically.

The judge's instructions were based on Kentucky Revised Statute (KRS) 508.032, Assault of a family member or member of an unmarried couple–KRS 508.030, Assault in the fourth degree (1982). Instructions asked participants to find the defendant guilty of assault in the 4th degree under the following instruction if, and only if, they believed from the evidence beyond a reasonable doubt all of the following: the defendant intentionally or wantonly caused physical injury to the victim, or with recklessness he caused physical injury to the victim by means of a deadly weapon or dangerous instrument (i.e., any instrument, including parts of the human body when a serious physical injury is a direct result of the use of that part of the human body, article, or substance which, under the circumstances in which it is used, attempted to be used, or threatened to be used, is readily capable of causing death or serious physical injury).

Comprehension check questions. Participants were asked a few basic comprehension questions throughout the mock trial summary to check that they read and understood the trial (e.g., "How does Jennifer Miller know the defendant?"). The response options were multiple choice, and if participants got them wrong as they completed the survey they were instructed to read the summary more carefully.

Trial questionnaire. Participants rendered verdicts (either *guilty* or *not guilty*), and indicated their confidence in their verdict on a seven point Likert scale (1 = *not at all confident* to 7 = *extremely confident*). They were also asked to indicate how guilty they thought the defendant was (1 = *the defendant is completely not guilty* to 7 = *the defendant is completely guilty*), how serious they thought the incident was (1 = *not at all serious* to 7 = *extremely serious*), and they were asked to indicate their reason(s) for their verdicts in an open-ended response. Participants also provided various ratings including the extent to which they blamed the victim and defendant, found them and their witnesses credible, believed them, found them to be honest, felt they were responsible for the injuries, and felt they were similar to a typical abuser or victim on a seven point Likert scale (1 = *not at all* to 7 = *completely*). Participants also indicated how much sympathy and pity they had for the victim and defendant, and how much anger they felt towards them on a seven point Likert scale from (1 = *none at all* to 7 = *a lot*). Though not a primary focus of our study, participants filled out trial ratings indicating their perceptions of the defendant to disguise the fact our study was focusing on perceptions of the victim. This questionnaire had twenty-eight total items. Related measures were averaged together to create the following subscales: victim credibility (victim credibility, victim honesty, victim believability; Cronbach's $\alpha = .97$), and victim blame (victim blame, victim responsible; $\alpha = .90$).

Social distancing measure. We used the Bogardus (1933) social distancing scale to determine the extent to which participants distance themselves from people with mental illness. Because this measure is long-standing and the original instructions are somewhat ambiguous, there are various interpretations as to how it should be used. Thus, for our study we used an adapted version (Wark & Galliher, 2007) that lists various groups and asks participants to indicate the closest level of intimacy they would be willing to have with a member of the group on a five point Likert scale (1 = *would marry*, 2 = *would have as a regular friend,* 3 = *would work beside in an office,* 4 = *would have to my street as neighbors,* 5 = *would have as citizens in my country*). These groups included the trial summary conditions (i.e., a person with an eating disorder, major depressive disorder, and fibromyalgia) as well as three filler groups (i.e., a person with a substance use disorder, a learning disability, and bipolar disorder). To develop a single measure of social distancing towards mental illness we averaged scores on eating disorder, major depressive disorder, substance use disorder, and bipolar disorder (Cronbach's $\alpha = .79$). High scores on this measure indicated greater social distance.

Depression Stigma Scale. We used Griffiths, Christensen, and Jorm's (2008) depression stigma scale personal subscale to gauge participants' personal attitudes and beliefs about depression. This scale asks participants to indicate the extent to which they agree or disagree with statements about depression (e.g., "I would not vote for a politician if I knew they had been depressed," and "depression is a sign of personal weakness") on a five point Likert Scale (1= *strongly disagree* to 5= *strongly agree*). This questionnaire had ten items, and the total score was calculated by summing the scores for each item (Cronbach's $\alpha = .88$). High scores on this measure indicated high levels of stigma towards depression.

Attitude towards mental illness scales. We used two dimensions of Norman, Sorrentino, Windell and Machanda's (2008) scale (i.e., personal responsibility for illness and continuity with normal) to assess participants' attitudes towards mental illness. This scale included statements such as "People develop ***** because they are easily stressed," and "Normal people can have some of the symptoms of *****." The blank spaces in the statements were filled in with a mental illness. The personal responsibility for illness subscale was only used to measure perceptions about eating disorders because the depression stigma scale assessed some of these same ideas, thus including both for depression would have been redundant. However, the continuity with normal subscale was used to measure attitudes about both eating disorders, and major depressive disorder, and a filler group of substance use disorder was also included. Participants indicated their agreement with the statements on a five-point Likert scale[3] (1= *strongly disagree* to 5= *strongly agree*). Both scales were calculated by averaging the scores of each item. The personal responsibility for illness subscale had four items ($\alpha = .89$) and the continuity with normal subscale had three items and was used for both eating disorder ($\alpha = .76$) and major depressive disorder ($\alpha = .82$). High scores on the personal responsibility for illness subscale indicated participants blamed people with eating disorders for their disorder, and high scores on the continuity with normal subscale indicated participants felt symptoms of the mental illness were normal.

Domestic Violence Myth Acceptance Scale (DVMAS). To measure participants' adherence to myths about domestic violence, we used Peters's (2008) DVMAS. It includes statements such as "domestic violence does not impact many people," and "if a woman continues

[3]The original version of this scale may have used a four point Likert scale, though this is not explicitly reported in the paper.

living with a man who beats her then it's her own fault if she is beaten again." Participants indicated their agreement with the statements on a six point Likert scale (1= *strongly disagree* to 6= *strongly agree*). This nineteen-item scale was calculated by summing the scores of each item (α = .93). High scores on this measure indicated strong adherence to myths about domestic violence.

Procedure

Participants were invited to participate in a two-part survey via MTurk, in which they were informed they would be asked questions about their beliefs and also have the opportunity to read a criminal assault trial summary and act as a juror. Interested parties were redirected to Qualtrics, an online survey tool used to present the study materials. Participants read over an informed consent document and provided their consent to participate before being able to continue with the study.

The first survey informed participants they would be asked questions typically asked in a jury selection process (e.g., about themselves and their beliefs). For this part of the study, participants filled out demographic questions, a question about their experience with mental illness, a question about their honesty as a juror, and a question about their belief in a just world. Such questions were included to improve the ecological validity of our study as these are questions that would be typically asked in a juror selection process, and also helped disguise the true purpose of the survey, which was to measure attitudes towards mental illness. Participants also filled out the following scales in a randomized order: depression stigma scale, personal responsibility for illness scale (eating disorder), continuity with normal subscale (for depression and eating disorders), the social distancing scale, and the DVMAS. Questions in the continuity with normal subscale were randomized so the presentation order of each mental illness would not

influence the participant. Participants completed this part of the study in approximately ten minutes. After completing the questionnaires, participants were informed they would be eligible to participate in an additional study within a few days in which they would act as a juror. Participants who opted into the mock juror study were randomly assigned to one of the four trial conditions, read the mock trial summary, answered comprehension check questions, and filled out the trial questionnaire. The mock juror part of the study took participants approximately fifteen minutes to complete.

Results

The overall conviction rate across all four conditions was 69.6%. Table 1 presents means and standard deviations for each of the primary dependent variables across all conditions. Prior to analyses, we created dummy variables to conduct comparisons for each of the mental illness conditions to the no illness reference group and physical illness reference group, and to compare the mental illness conditions to each other. To analyze the predicted associations across trial ratings, we employed a series of hierarchical linear regressions. The first step of each regression model included gender, the second step included the scores on one of the various attitude scales (i.e., depression stigma, personal responsibility for eating disorder, continuity with normal for major depression, continuity with normal for eating disorder, and social distancing; a separate model was run for each attitude scale), the third step of the model consisted of the dummy variables for each illness condition, and the fourth step of the model consisted of interaction terms (i.e., dummy variable X attitude measured). Given that the attitude scales are highly correlated with each other (see Hypothesis 4 results), we ran separate models for each of the attitude scales to avoid issues with multicollinearity. Linear regressions were conducted for the following five trial rating variables: victim credibility, victim blame, anger towards the victim,

sympathy towards the victim, and pity for the victim. Similarly, to analyze the dichotomous verdict results, we conducted a series of hierarchal logistic regressions models that included the same steps as the linear regressions. For each logistic regression model, the dependent variable measured was verdict, and the only thing that varied between models was which attitude scale was included. Models were run first with the neutral condition as the reference group, then with the fibromyalgia condition as the reference group, and finally with eating disorder as the reference group to make comparisons between the conditions. Finally, to analyze the extent to which scores on the various attitude scales correlated with each other we ran a Pearson's correlation.

Hypothesis 1: Main effects of trial condition on verdict and trial ratings. Trial condition was a significant predictor for anger towards the victim, as this model was significant at Step 3 (R^2 = .24, F [5, 190] = 11.58, p < .001). While anger towards the victim was low across all conditions (see Table 1, Figure 2), anger towards the victim was lower towards victims with major depression (β = -.18, t = -2.32, p = .021) and eating disorder (β = -.19, t = -2.33, p = .019) compared to victims with no illness, in contrast to our hypotheses. Also, the anger toward the victim model was significant at Step 4 (R^2 = .29, F [8, 190] = 9.25, p = < .001) indicating a significant main effect of victim depression compared to eating disorder: participants were angrier toward the victim with depression than the victim with an eating disorder (β = .58, t = 2.62 p =.009). However, these main effects of victim mental illness were qualified by significant interactions (see Hypothesis 2 below). The model for victim blame was significant at Step 3 (R^2 = .24, F [5, 190] = 11.82, p = <.001), but the dummy variables were not significant predictors at this step. Additionally, the victim blame model was significant at Step 4 (R^2 = .24, F[8, 190] = 8.35, p < .001), indicating a significant main effect of victim depression compared to eating

disorder: participants blamed the victim with depression more than the victim with an eating disorder (β = .50, t = 2.21, p = .029). This effect was also qualified by an interaction (see Hypothesis 2 below) though victim blame was low across all conditions. The model for victim sympathy was also significant at Step 3 (R^2 = .06, F [5, 190] = 2.36, p = .042), but the dummy variables were not significant predictors in that model. Victim credibility, and pity for the victim were not significant at Step 3 (all p's <.05). Trial condition did not predict verdict as the logistic regression models were not significant at Step 3 (all p's > .05).

Hypothesis 2: Moderating effects of stigma on verdict and trial ratings. We predicted stigmatizing attitudes such as depression stigma, stigma towards eating disorder, and social distancing scores (i.e., the level of intimacy a person is willing to have with a person who has a mental illness) would interact with the victim mental health conditions to predict an increase in negative perceptions of the victim (e.g., victim blame). Also, we predicted the perception of major depression or eating disorder as being normal would also interact with the victim mental health conditions to predict a decrease in negative victim perceptions. Of the linear regression models testing the effect of depression stigma on trial ratings, three were significant at Step 2, indicating main effects of depression stigma: victim blame (R^2 = .24, F [2,190] = 28.97, p < .001), sympathy toward the victim (R^2 = .04, F [2, 190] = 4.38, p = .014), and anger toward the victim (R^2 = .20, F [2, 190] = 23.88, p <.001). As stigma towards depression increased, victim blame also increased (β = .49, t = 7.61, p < .001), sympathy for the victim decreased (β = -.15, t = -2.03, p = .044), and anger towards the victim also increased (β = .46, t = 6.89, p < .001).

Furthermore, the main effects of depression stigma on victim blame and anger toward the victim were qualified by significant interactions. The victim blame model was significant at step 4 (see Figure 1), as there was a significant interaction between DSS scores and victim health

condition on victim blame for the depression condition (β = -.46, t = -2.21, p = .029). A probe of the interaction using a bootstrapping procedure (PROCESS; Hayes, 2013) indicated that for participants at low (-1*SD*) levels of depression stigma, they blamed the victim with depression more than the victim with an eating disorder (95% CI [.01, 1.30]) which is consistent with our hypothesis that victims with depression would be perceived more negatively than victims with an eating disorder. At mean levels of depression stigma, the victim having depression did not affect victim blame, but for participants at high (+1*SD*) levels of depression stigma, they blamed the victim with depression less than the victim with no illness (95% CI [-1.47, -.11]) and fibromyalgia (95% CI [-1.37, -.02]), which was not consistent with our hypotheses. We also found an interaction with depression condition at Step 4 of the anger toward the victim model (see Figure 2), (β = -.72, t = -3.47, p = .001). A probe of the interaction indicated that participants at low (-1*SD*) levels of depression stigma had more anger toward the victim with depression than the victim with an eating disorder (95% CI [.08, 1.37]). Contrary to our hypotheses, participants at mean and high (+1*SD*) levels of depression stigma had less anger toward the victim with depression than the victim with no illness (95% CI [-2.10, -.74]) and fibromyalgia (95% CI [-1.92, -.57]). Participants at high (+1*SD*) levels of depression stigma had less anger toward the victim with depression than the victim with an eating disorder (95% CI [-1.56, -.14]). Victim sympathy was also significant at Step 4 (R^2 = .09, F [8, 190] = 2.26, p = .025), but the interaction terms were not significant (all p's > .05). Also, the models for victim credibility, and victim pity were not significant at Step 4 (R^2 = .07, F [8, 190] = 1.60, p = .128; R^2 = .04, F [8, 190] = 1.05, p = .402, respectively). Depression stigma was not a significant predictor of verdict (χ^2 = 3.90, p = .142).

Of the models testing the effect of eating disorder stigma (i.e. personal responsibility for eating disorder) on perceptions of the victim, four models were significant at Step 2: victim credibility (R^2 = .06, F [2, 190] = 5.54, p = .005), victim blame (R^2 = .25, F [2, 190] = 31.89, p < .001), sympathy towards the victim (R^2 = .05, F [2, 190] = 5.22, p = .006) and anger towards the victim (R^2 = .17, F [2, 190] = 18.69, p < .001). Stigma towards eating disorder predicted a decrease in victim credibility scores (β = -.19, t = -2.70, p = .008) and sympathy for the victim (β = -.17, t = -2.40, p = .017), and an increase in victim blame scores (β = .51, t = 7.98, p < .001), and anger towards the victim (β = .41, t = 6.09, p < .001) overall. Step 4 of the model was not significant (all p's > .05), and eating disorder stigma was not a significant predictor of verdict (χ^2 = 5.55, p = .062).

Three models examining social distancing effects on trial ratings were significant at Step 2: victim blame (R^2 = .07, F[2, 190] = 7.57, p = .001), victim sympathy (R^2 = .05, F[2, 190] = 4.40, p = .014), and anger toward the victim (R^2 = .06, F [2, 190] = 6.41, p = .002). Social distancing (high scores equal greater distance from a person with mental illness) predicted increased victim blame (β = .27, t = 3.89, p < .001), decreased sympathy towards the victim (β = -.15, t = -2.04, p =.043), and increased anger towards the victim (β = .25, t = 3.55, p < .001). The interaction terms were not significant in the model including social distancing (all p's > .05), and social distancing scores did not predict verdict (χ^2 = .903, p = .34).

Three models examining effects of continuity with normal for major depression on trial ratings were significant at Step 2: victim credibility (R^2 = .04, F [2, 190] = 4.03, p = .019). victim sympathy (R^2 = .05, F [2, 190] = 5.37, p = .005), and victim pity (R^2 = .05, F [2, 190] = 4.58, p = .011). Perceiving depression as normal predicted an increase in victim credibility scores (β = .15, t = 2.12, p = .035), an increase in sympathy towards the victim (β = .18, t = 2.46, p = .015), and

increase in pity towards the victim (β = .18, t = 2.48, p = .014). Continuity with normal for major depression was also the only variable that increased the likelihood of rendering guilty verdicts as it was significant at Step 2 of the logistic regression (χ^2 = 4.10, p = .043); increased perception of depression as normal predicted increased guilty verdicts (OR = 1.45, p = .043). Step 4 of this model was not significant (all p's > .05).

Two of the models examining the effects of continuity with normal for eating disorders on trial ratings were significant at Step 2: victim pity (R^2 = .04, F [2, 190] = 4.19, p = .017), and victim anger (R^2 = .02, F [2, 190] = 2.36, p = .097). The perception of eating disorders as normal increased victim pity scores (β = .17, t = 2.32, p = .021), but unexpectedly also predicted an increase in anger towards the victim (β = .15, t = 2.12, p = .035). None of the interaction terms for this model were significant (all p's > .05), and continuity with normal for eating disorders did not predict verdict (χ^2 = .901, p = .34).

Hypothesis 3: Gender effect on trial ratings. Gender affected emotional responses to the victim in the predicted direction of our hypothesis (see Figure 3). Specifically, the model for sympathy towards the victim (R^2 = .024, F [1, 190] = .4.55, p = .034) was significant at Step 1. Women had more sympathy towards the victim than men (β =.15, t = 14.58, p = .034).

Hypothesis 4: Correlation of scores on attitude scales. To test for the prediction that depression stigma, personal responsibility for eating disorder, social distancing, and scores on DVMAS would all positively correlate with each other and negatively correlate with scores on the continuity with normal scales, we ran Pearson's correlations. Table 2 presents correlations between each of the attitude scales. As indicated, depression stigma scores were significantly positively correlated with scores on the personal responsibility for eating disorder scale *(r* = .64

$p < .001$), the social distancing scale ($r = .51$, $p < .001$), and the domestic violence myth acceptance scale ($r = .70$, $p < .001$).

Similarly, personal responsibility for eating disorder positively correlated with social distancing scores ($r = .468$, $p < .001$), and positively correlated with DVMAS *(*$r = .679$, $p < .001$), which suggests participants that blamed people with an eating disorder for their condition and socially distanced themselves from people with mental illness were also likely to support myths about domestic violence. However unexpectedly, continuity with normal for eating disorder was found to positively correlate with personal responsibility for eating disorder ($r = .146$, $p = .044$), and with DVMAS ($r = .175$, $p = .016$). These findings were opposite than hypothesized, and suggest people that viewed eating disorders as normal also blamed a person with an eating disorder for their condition, and supported myths about domestic violence. Lastly, more in line with our hypotheses, we found continuity with normal for major depression negatively correlated with social distancing ($r = -.168$, $p = .020$), suggesting participants who identified depression as normal were less likely to distance themselves socially from people with mental illness.

Discussion

Mental illness is both stigmatized (Griffiths et al., 2015; Makenzie et al., 2019) and stereotyped (Fiske, 2012; Sadler et al., 2012), and jurors tend to rely on their biases in making decisions in cases where the evidence is ambiguous (Kleider et al., 2012). As such, we predicted that in cases of IPV where the victim has a mental illness, victims would be perceived more negatively, and mock jurors would have less pro-victim judgments (e.g., finding the victim credible, rendering guilty verdicts). In particular, we expected that participants who held highly stigmatized views toward mental illness and distanced themselves socially from people with

mental illness would perceive the victim with a mental illness most negatively overall and render the least number of guilty verdicts. Support for these hypotheses were mixed. Though we predicted stigma and social distancing would have moderating effects on trial ratings and verdict, they actually had main effects across all conditions in predicting the following: an increase in victim blame, a decrease in sympathy towards the victim, and an increase in anger towards the victim. Furthermore, scores on depression stigma and the personal responsibility for eating disorder scale correlated with domestic violence myth acceptance scores, which suggests people who tend to victim blame may also engage in blaming people for their mental illness, and ultimately may tend to blame victims more broadly. Contrary to past research, female participants did not render more guilty verdicts than male participants. However, female participants were more pro-victim on trial ratings as female participants had more sympathy for the victim than male participants.

One finding that was not congruent with our hypotheses was the interaction of trial condition with depression stigma on victim blame and anger. While we anticipated there would be an interaction on depression stigma and trial condition on the various trial ratings, the direction of these relationships were opposite of what we hypothesized (i.e., for participants exposed to the depression condition, as scores on the depression stigma scale increased, victim blame and anger towards the victim decreased relative to all other conditions). It is possible that these surprising results could be due in part to the fact that victim's depression was made salient in this condition, and participants may have been motivated to appear non-prejudiced (e.g., Sommers & Ellsworth, 2001). Alternatively, a person high in depression stigma might also be less likely to blame a victim with depression as they might view them as "incompetent," or

incapable of deciding what is best for themselves, and therefore they might not blame them for staying in an abusive relationship.

It is worth noting, the continuity with normal scales for both major depression and eating disorders were the only predictors of pity toward the victim. Perceptions of major depression and eating disorders as normal would typically reflect that people view people with these conditions as a part of their ingroup, however pity is typically reserved only for outgroups high in warmth and low in competence on the stereotype content model (e.g., the elderly, or people with a disability, Fiske et al, 2002). This discrepancy could suggest that participants might view these mental illnesses as normal, but might not fully embrace people with these mental illnesses as a part of their ingroup, however more research is necessary to fully parse out the relationship between continuity with normal ratings and the stereotype content model.

Furthermore, continuity with normal for eating disorder scores predicted pity towards the victim and anger towards the victim. These findings are seemingly in contrast with each other, however they could reflect that participants that perceive eating disorders as normal may feel sorry for a victim, but ultimately be angry with them for being in an abusive situation. Results from the Pearson's correlations tests of the attitude measures lend further support of this theory, as both stigma towards eating disorders and perceptions of eating disorders as normal positively correlated with each other and positively correlated with domestic violence myth acceptance, suggesting people that view eating disorders as normal still blame the person for their condition, and accept myths about domestic violence. Thus, though participants might be willing to view people with eating disorders as normal, they still have a tendency to blame them for their circumstances both in terms of their health and their involvement in an abusive relationship.

Findings that people who tended to stigmatize mental illness also engaged in victim blaming more generally is of great interest, and could reflect a connection to need for cognition. Need for cognition is an individual characteristic marked by the extent to which an individual is willing to engage in complex thinking and effortful information processing (Petty, DeMarree, Briñol, Horcajo, & Strathman, 2008). Correlations of stigma scores and domestic violence myth acceptance scores could suggest lack of need for cognition among participants that score high on these measures, and an unwillingness to understand and empathize with people with mental illness or victims of IPV. Because people who stigmatize mental illness not only direct their biases towards people with mental illness, but also blame victims that do not have mental illness, it may be worth screening all potential jurors for biases against people with mental illness as another means of detecting victim blaming. Ultimately, striving to reduce biases and victim blaming as much as possible should help to give victims a fair case, and could help to improve their experience with the courts overall.

Limitations & Future Directions

Contrary to our predictions, stigmatizing attitudes and social distancing did not predict verdict, nor did trial condition, and participant gender was also not associated with verdict preferences. Thus, even though stigma affected attitudes towards the victim, stigma did not directly predict verdict. It is possible the evidence of the case was not as ambiguous as we had intended it to be, and as such participants may have rendered more guilty verdicts across all conditions (69.6%) than is standard in such cases as guilty verdict usually fall around 50% in mock juror studies of victimization (e.g., 54% of participants rendered guilty verdicts in Wasarhaley and Vilk's 2019 study).

In addition to the aforementioned limitations to the study design, there were also some limitations in how participants were recruited for this study. Amazon's MTurk service is useful in that it allowed us to require participants be eligible for jury service (U.S. citizen eighteen or older). Also, it allowed us to sample a population that would be more representative of potential jurors than the psychology undergraduate research pool sample (e.g. wide age range, and can sample participants from all around the U.S.). However, participants tend to be White, young, and liberal compared to the general population (Berinsky, Huber, & Lenz, 2012), which was similar to our specific sample. This sampling method also is not inclusive of people who do not readily have access to the internet, or are unfamiliar with this service. Furthermore, though we tried to avoid self-selection bias by being vague in our description of the experiment on MTurk, it is possible that this may have affected our sample. We advertised our study on MTurk as a legal decision making study and explained participants would read about a randomly selected legal issue, so people that have no interest in law may have opted to pass over our study, whereas people that are interested in law may have chosen to participate based on the fact they felt they were a "good fit" for our study. As such, our sample may not be wholly representative of a typical juror sample, and may reflect a varying degree of understanding or interest in law compared to a typical jury.

Furthermore, our study also faced challenges in ensuring ecological validity. Because this was an online study, participants were not in a court setting, and they did not get to see a physical victim, defendant, or witness, nor were they able to hear the testimony out loud, thus their interpretation of the events relied on how they read and perceived the trial summary. Participants also did not have the opportunity to view any physical evidence that may have also elicited an emotional response. Furthermore, participants did not have fellow jurors to deliberate

with in making their decision. It is possible that deliberating with other people could lead to a different decision than an individual juror would have made on their own (Salerno & Diamond, 2010).

An area of research that could be relevant for future researchers to explore is how the victim having a substance use disorder affects perceptions of the victim in IPV cases. Substance use disorder is common among victims of domestic violence as women who have experienced domestic violence compared to those who have not are fifteen times likelier to abuse alcohol and nine times likelier to abuse drugs (Stark & Flitcraft, 1996). Researchers looking to study this issue could have different trial conditions in which the victim has a substance use disorder (e.g., alcohol dependency or opioid dependency), and a mental illness comparison group (e.g., depression). These comparisons could illuminate differences in how major depressive disorder is perceived relative to substance use disorder as major depressive disorder falls at a much more favorable location on the SCM than substance use disorder (Sadler et al., 2012). Furthermore, this comparison could potentially illuminate differences in perceptions of victims with alcohol dependency compared to opioid dependency as the general population tends to rate opioid abuse as being more severe than alcohol abuse, and believe people addicted to alcohol to have a better chance of recovery than people with opioid abuse (Corrigan, Qin, Davidson, Schomerus, Shuman, & Smelson, 2019). As such, participants might consider alcohol abuse more normal, or acceptable compared to opioid abuse.

With regard to our study design, our trial summaries only subtly alluded to the victim's condition in the victim and defendant's respective testimony. However, this issue may play out more explicitly in a legal setting in other ways. For instance, in an Iowa Supreme Court case, *State v. Cashen*, a defendant in an IPV case was successfully able to petition to have the victim's

mental health records brought in to the court to be used as evidence. These records revealed the victim had been in therapy since she was fifteen, and had been formally diagnosed with post-traumatic stress disorder, anxiety, and depression for which she was taking antidepressants. The victim's medical records also noted her history of impulsive and reactive behaviors. Not only was the defendant ultimately exonerated from the charges based on the evidence contained in the victim's medical records, but the supreme court decision also set up a procedure in which the victim's medical records could be used as evidence in Iowa courts (del Busto, & Sadoff, 2012). Likewise, in family law litigation, a parent may try to frame their co-parent as having a mental illness in an attempt to paint them as unfit to parent (Markham, 2003). Thus, future research warrants investigating how these perceptions play out in other legal contexts when the victim's condition is more apparent.

Overall, findings that stigmatizing attitudes towards mental illness predicted negative perceptions of the victim, though expected, are worrisome. All victims should be entitled to a fair trial, and should not be subjected to un-due blame. Thus, it may be worth screening potential jurors for biases against mental illness to serve as a proxy for victim blaming more generally.

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Table 1

Guilty Verdict Ratings and Attitude and Trial Ratings by Experimental Condition

	Mean (SD)			
Variable	Eating Disorder (n = 45)	Major Depressive Disorder (n = 46)	Fibromyalgia (n = 52)	Neutral (n = 48)
Guilty Verdict Rate	75.6%	67.4%	73.1%	62.5%
Victim Credibility	5.65 (1.32)	5.49 (1.51)	5.39 (1.35)	5.15 (1.51)
Victim Blame	1.82 (1.23)	2.05 (1.31)	2.29 (1.42)	2.30 (1.56)
Anger toward Victim	$1.44\ (1.01)_{a}$	$1.57\ (1.04)_{b}$	$2.12\ (1.57)_{abc}$	$2.23\ (1.72)_{c}$
Sympathy for Victim	5.71 (1.52)	5.48 (1.41)	5.63 (1.31)	5.27 (1.57)
Pity for Victim	5.27 (1.62)	5.22 (1.60)	5.37 (1.63)	4.77 (1.74)

Note. Participants rated victim blame and credibility items from 1 = *not at all* to 7 = *completely*, and rated sympathy, pity and anger towards the victim from 1 = *none at all* to 7 = *a lot*. Different letter subscript denotes significant difference ($p < .05$); ratings presented as $M(SD)$.

Table 2

Correlations between attitude scales.

	2	3	4	5	6
1. Depression Stigma Scale	-.138	.115	.643**	.508**	.689**
2. Continuity With Normal Major Depressive Disorder		.503**	-.101	-.168*	-.072
3. Continuity With Normal Eating Disorder			.146*	.006	.175*
4. Personal Responsibility for Eating Disorder				.525**	.679**
5. Social Distance Scale					.468**
6. Domestic Violence Myth Acceptance Scale					

Note. Depression stigma, continuity with normal, and personal responsibility scales were rated on a scale of 1= *strongly disagree* to 5= *strongly agree*. The social distancing scale was rated on a scale of 1 = *would marry*, 2 = *would have as a regular friend,* 3 = *would work beside in an office,* 4 = *would have to my street as neighbors,* 5 = *would have as citizens in my country*. Domestic violence myth acceptance was rated on a scale of 1= *strongly disagree* to 6= *strongly agree*. * $p < .05$ ** $p < .01$

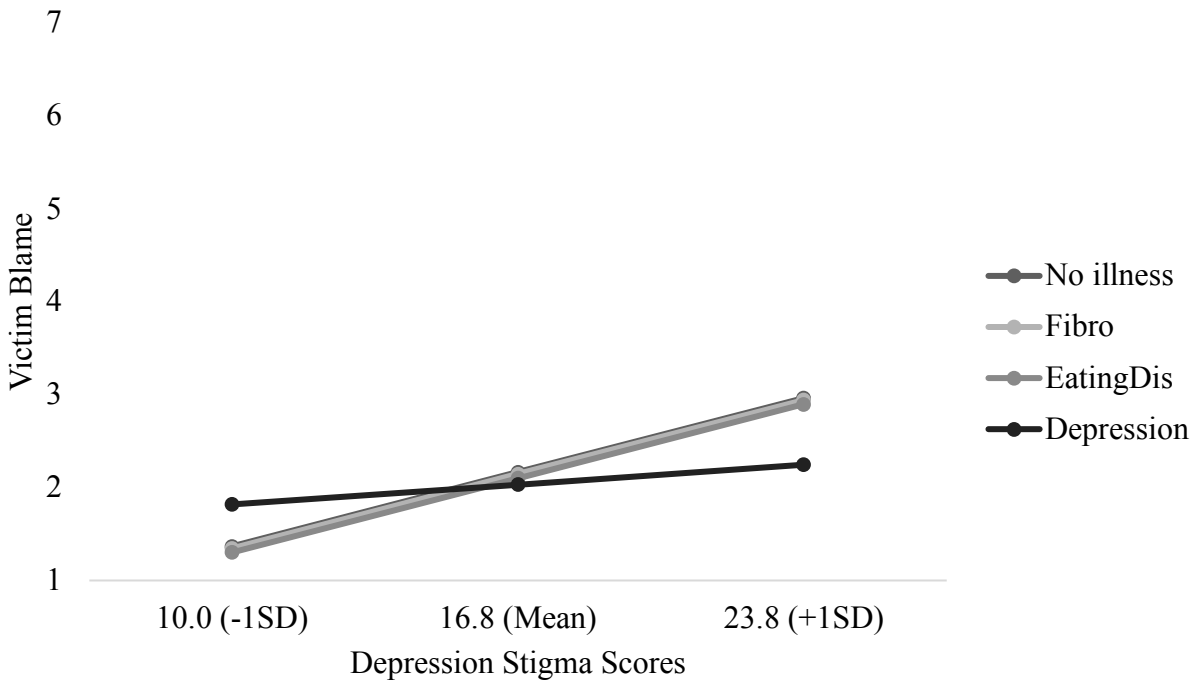

Figure 1. Interaction between depression stigma and victim health condition on victim blame.

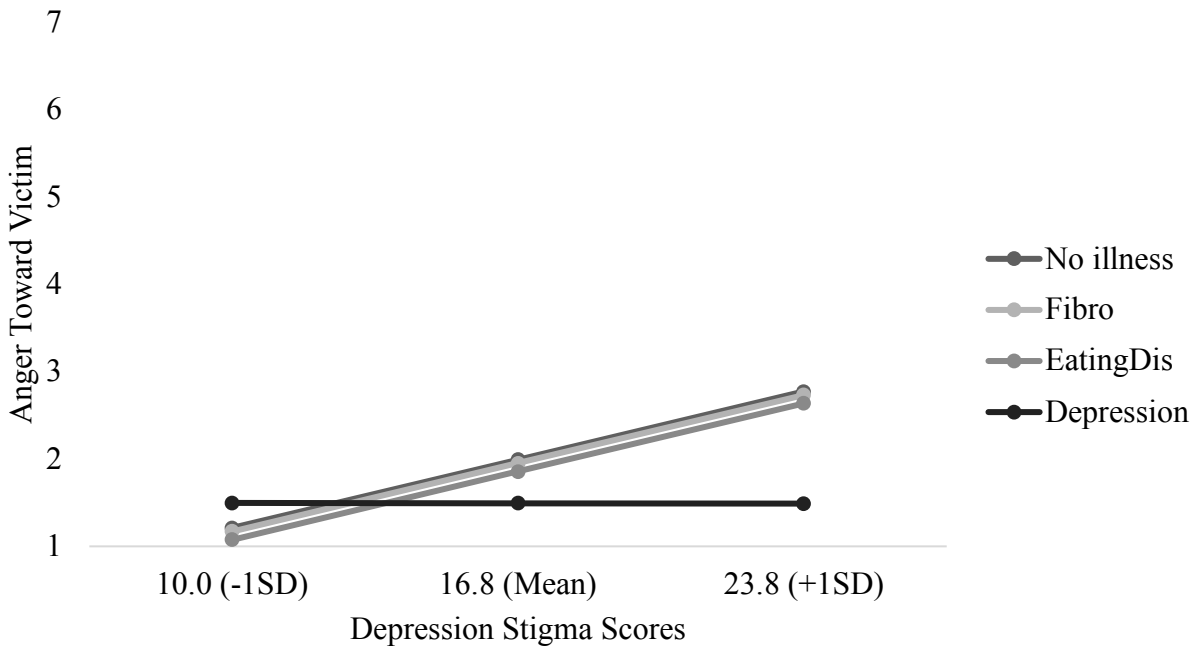

Figure 2. Interaction between depression stigma and victim health condition on anger towards the victim.

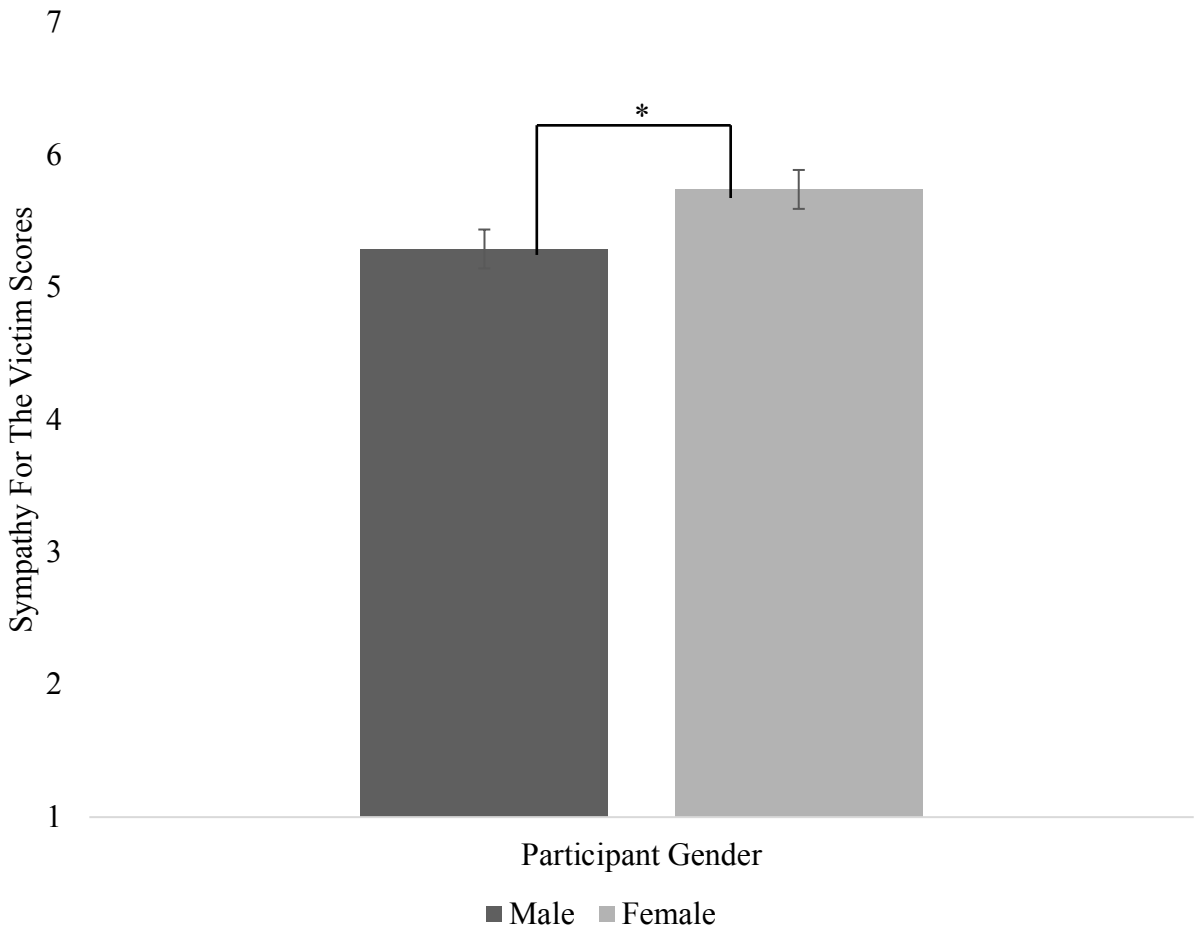

Figure 3. Emotional responses to the victim by participant gender (*$p < .05$).

Appendix

Major Depression Condition Trial Summary

The Commonwealth of Kentucky vs. Michael Taylor (Defendant)
KRS 508.030 Assault in the 4th degree

Case background:

This is a criminal trial for the alleged assault of Jennifer Miller by the defendant, Michael Taylor. The allegations stated that the above-named defendant assaulted his girlfriend, Jennifer Miller, in their residence in Fayette County, Kentucky, on the evening of October 11, 2015 at approximately 6:30pm.

The state called on two witnesses for the prosecution: Jennifer Miller (alleged victim) and Robert Nelson, M.D. (the emergency room doctor who examined Jennifer Miller).

Michael Taylor pleaded not guilty. The defense stated that the defendant and his girlfriend (alleged victim, Jennifer Miller) were having an argument, and Jennifer Miller was injured by accident. The defense also argued that Michael Taylor would never intentionally hurt his girlfriend, Jennifer Miller. The defense called two witnesses: Vanessa Walsh (co-worker of the defendant) and Michael Taylor (the defendant).

Prosecution's Case
Prosecution Witness No. 1: Jennifer Miller (alleged victim)

Direct Examination

Jennifer Miller stated that she and the defendant, Michael Taylor, were in a committed relationship for over two years and had been living together for about eight months.

Ms. Miller stated that on the night in question, she was cleaning the kitchen when he arrived home from work. Mr. Taylor began criticizing Ms. Miller for letting the laundry pile up and for not cleaning the house. Then he said that Ms. Miller doesn't work as hard as he does all day, at least she could keep the house clean. Ms. Miller became upset as Mr. Taylor continued to nag her about household duties. Then he called her a "crybaby deadbeat," which she found extreme hurtful given her recent struggle with major depression.

As both of their anger heightened, Ms. Miller began to shout at Mr. Taylor and threatened to leave him if he did not back off. Ms. Miller stated that at that point, the defendant grabbed her by the arm and punched her in the face, knocking her to the floor, and kicked her on her hip. Ms. Miller remained on the floor as Mr. Taylor left the house. Ms. Miller then called the police to report the incident.

Prosecution Witness No. 1: Jennifer Miller (alleged victim)

Cross Examination

Jennifer Miller stated that while she and Mr. Taylor had engaged in verbal arguments before, Mr. Taylor had never physically assaulted her prior to this incident. Ms. Miller had never seen Mr. Taylor act physically violent before.

Prosecution Witness No. 2: Dr. Robert Nelson

Direct Examination

Dr. Nelson stated that he is a licensed doctor. He received his M.D. from Vanderbilt University and has testified in ten other court trials. Dr. Nelson stated that he performed a physical exam on the alleged victim, Jennifer Miller, in the emergency room at the hospital. Dr. Nelson indicated that Ms. Miller sustained a black eye, a sprained wrist, and a large contusion on her hip. He indicated that these injuries were consistent with Ms. Miller's description of the incident.

Cross Examination

Dr. Nelson admitted that he did not know for certain how Jennifer Miller's injuries were sustained and who, if anyone, had caused them.

Defendant's Case

Defense Witness No. 1: Vanessa Walsh (defendant's co-worker)

Direct Examination

Vanessa Walsh stated that she was a co-worker of the defendant, Michael Taylor, and had known him for five years. Ms. Walsh stated that the defendant is a caring person and an excellent employee at work. Ms. Walsh stated that the day before the incident, October 10, 2015, the defendant spoke to Ms. Walsh and told her that he was going through some relationship issues and was planning to talk to his girlfriend Jennifer about them. The defendant had said that his girlfriend Jennifer seemed more concerned with her own life than she did about their relationship and helping maintain their home. Ms. Walsh said she felt that the defendant was upset with his girlfriend Jennifer, but did not seem angry.

Cross Examination

Ms. Walsh said that in the five years she has known the defendant, the defendant has never had any issues in the workplace. Ms. Walsh also admitted that she does not see everything Mr. Taylor does, nor does Mr. Taylor tell her everything.

Defense Witness No. 2: Michael Taylor (defendant)
Direct Examination

The defendant, Michael Taylor, stated that he and Jennifer Miller were in a 2-year relationship

and shared a residence for 8 months. At the time of the incident, he was working lots of over time while his girlfriend Jennifer Miller was supposed to be responsible for maintaining the house.

The defendant stated that on the night in question, he had arrived home from work to find his girlfriend Ms. Miller lazily cleaning the kitchen, and the laundry still had not been done even though she had promised it would be. The defendant tried to talk to Ms. Miller about putting more effort into the household duties. Ms. Miller got angry and began shouting obscenities at him, calling him a "nagging bastard." The defendant stated that he tried to comfort Ms. Miller by putting his arm around her but Ms. Miller pushed him away. Ms. Miller threatened to leave so the defendant grabbed Ms. Miller, accidentally causing her to fall onto the floor. Ms. Miller screamed for the defendant to get away from her so the defendant left the house.

Defense Witness No. 2: Michael Taylor (defendant)

The defendant stated that he was surprised to be confronted by a police officer when he returned home. He and Ms. Miller had had verbal arguments previously, but never hurt each other physically. He admitted that they were arguing more than normal lately due to increased financial stress from paying for Ms. Miller to receive therapy for her major depression. The defendant also indicated that he did not realize in the moment that Ms. Miller had injured her eye, but said that Ms. Miller must have hit her face on the kitchen island or the tile floor when she fell. He suggested that Ms. Miller must have bruised her hip when she fell as well.

Defense Witness No. 2: Michael Taylor (defendant)

Cross Examination

Mr. Taylor admitted that he was upset with Ms. Miller the night of the incident. He acknowledges that their argument got out of hand and that he did grab Ms. Miller's arm. He said he may have grabbed at her harder than he realized because he had not intended to make Ms. Miller fall.

Instructions to Jurors

You will find the Defendant guilty of Assault in the 4th degree under the following Instruction if, and only if, you believe from the evidence beyond a reasonable doubt all of the following:

That in the above-stated county on or about October 11, 2015, the defendant, Michael Taylor
(a) Intentionally or wantonly caused physical injury to Jennifer Miller;
OR
(b) With recklessness he caused physical injury to Jennifer Miller by means of a deadly weapon or a dangerous instrument.

Note: "Dangerous instrument" means any instrument, including parts of the human body when a serious physical injury is a direct result of the use of that part of the human body, article, or

substance which, under the circumstances in which it is used, attempted to be used, or threatened to be used, is readily capable of causing death or serious physical injury.

Closing Arguments: Prosecution

The prosecution concluded that Mr. Taylor should be found guilty and convicted of assault in the 4th degree. The law states that a person is guilty of 4th-degree assault when he deliberately causes physical injury to someone. The prosecution emphasized that the defendant used his hands and feet as dangerous weapons to assault Jennifer Miller and caused her to suffer serious injuries. This incident has caused Ms. Miller a lot of distress because the defendant was a person that she trusted. The prosecution restated that the defendant should be found guilty.

Closing Arguments: Defense

The defense argued that there was no evidence other than Ms. Miller's allegations to convict Mr. Taylor of assault in the 4th degree. The defense noted that this crime must be proven beyond a reasonable doubt and there is more than enough reasonable doubt that the injuries Ms. Miller showed to the doctor were intentionally caused by Mr. Taylor. The defense argued that Mr. Taylor does not have a history of physically harming anyone. The defendant would never hurt Ms. Miller and has always respected her. Furthermore, the defense said that Ms. Miller clearly was mad at the defendant after their verbal argument and called the police on him as a way to get back at him. Finally, the defense stated that the defendant should be found not guilty.

Closing Arguments: Prosecution

The prosecution stated that even if Mr. Taylor does not have a history of abusive behavior, he committed a crime by physically striking Ms. Miller. The prosecution restated that the defendant caused Ms. Miller's injuries and should be found guilty.